		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010058

Facility Name: Illinois Knights Templar Home

Address: P.O. Box 49 (Number) Paxton (City) 60957 (Zip Code)

County: Ford

Telephone Number: 217-379-2116 **Fax #** 217-379-3000

IDPA ID Number: 370724685001

Date of Initial License for Current Owners: 05/07/05

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501c3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Lawrence Travis **Telephone Number:** 217-528-9556

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 08/01/2003 to 07/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Lawrence A Travis, CPA
(Firm Name & Address) Lawrence Travis & Co PC, 1700 S. 1st St, Springfield, Il 62704
(Telephone) 217-528-9556 Fax # 217-528-1056

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 365

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,000	1
2		Skilled Pediatric (SNF/PED)			2
3	4	Intermediate (ICF)	4	1,460	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	26,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,944	6,472	1,114	18,530	8
9	SNF/PED					9
10	ICF	1,460			1,460	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,404	6,472	1,114	19,990	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.55%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/01/1954

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 18 and days of care provided 1,192

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 07/31/2004 Fiscal Year: 07/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 **Report Period Beginning:** 08/01/2003 **Ending:** 07/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	239,244	12,476	8,751	260,471		260,471		260,471			1
2	Food Purchase		108,715		108,715		108,715		108,715			2
3	Housekeeping	135,398	14,896	857	151,151		151,151		151,151			3
4	Laundry	42,713	7,648	3,232	53,593		53,593		53,593			4
5	Heat and Other Utilities			64,147	64,147		64,147	(4,675)	59,472			5
6	Maintenance	88,777	15,705	53,864	158,346		158,346		158,346			6
7	Other (specify):*											7
8	**TOTAL General Services**	506,132	159,440	130,851	796,423		796,423	(4,675)	791,748			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	749,257	118,507	472,247	1,340,011		1,340,011		1,340,011			10
10a	Therapy		739	87,183	87,922		87,922		87,922			10a
11	Activities	78,378	1,580	13,298	93,256		93,256		93,256			11
12	Social Services	31,619	776	2,528	34,923		34,923		34,923			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	859,254	121,602	583,656	1,564,512		1,564,512		1,564,512			16
	C. General Administration											
17	Administrative	27,558		58,673	86,231		86,231		86,231			17
18	Directors Fees											18
19	Professional Services			155,017	155,017		155,017	(760)	154,257			19
20	Dues, Fees, Subscriptions & Promotions			34,131	34,131		34,131	(16,422)	17,709			20
21	Clerical & General Office Expenses	120,546	28,619	61,061	210,226		210,226		210,226			21
22	Employee Benefits & Payroll Taxes			526,429	526,429		526,429		526,429			22
23	Inservice Training & Education			567	567		567		567			23
24	Travel and Seminar			7,589	7,589		7,589		7,589			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			170,088	170,088		170,088		170,088			26
27	Other (specify):*											27
28	**TOTAL General Administration**	148,104	28,619	1,013,555	1,190,278		1,190,278	(17,182)	1,173,096			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,513,490	309,661	1,728,062	3,551,213		3,551,213	(21,857)	3,529,356			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Illinois Knights Templar Home #0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			148,427	148,427		148,427		148,427			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			148,427	148,427		148,427		148,427			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	16,294	1,166	652	18,112		18,112		18,112			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,826	30,826		30,826		30,826			42
43	Other (specify):*							(27,354)	(27,354)			43
44	**TOTAL Special Cost Centers**	16,294	1,166	31,478	48,938		48,938	(27,354)	21,584			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,529,784	310,827	1,907,967	3,748,578		3,748,578	(49,211)	3,699,367			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,675)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(760)	19		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(16,422)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5a	(27,354)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,211)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (49,211)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Illinois Knights Templar Home

ID# 0010058

Report Period Beginning: 08/01/2003

Ending: 07/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Chamber of Commerce Dues	$ (25)	43	1
2	CLU Expenses	(20,048)	43	2
3	Townhouse Expenses	(7,281)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,354)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Illinois Knights Templar Home # 0010058 **Report Period Beginning:** 08/01/2003 **Ending:** 07/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,675)	0	0	0	0	0	0	0	0	0	0	(4,675)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,675)	0	0	0	0	0	0	0	0	0	0	(4,675)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(760)	0	0	0	0	0	0	0	0	0	0	(760)	19
20	Fees, Subscriptions & Promotions	(16,422)	0	0	0	0	0	0	0	0	0	0	(16,422)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(17,182)	0	0	0	0	0	0	0	0	0	0	(17,182)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,857)	0	0	0	0	0	0	0	0	0	0	(21,857)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Illinois Knights Templar Home** **#** **0010058** **Report Period Beginning:** **08/01/2003** **Ending:** **07/31/2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(27,354)	0	0	0	0	0	0	0	0	0	0	(27,354)	43
44	**TOTAL Special Cost Centers**	(27,354)	0	0	0	0	0	0	0	0	0	0	(27,354)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(49,211)	0	0	0	0	0	0	0	0	0	0	(49,211)	45

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 7/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		N/A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 7/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Illinois Knights Templar Home COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0010058

CONTACT PERSON REGARDING THIS REPORT N/A

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,268 B. General Construction Type: Exterior Brick Frame Fire Resistive Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Illinois Knights Templar Home - Townhouse Apartments; 2862 Sq Ft; 4 units
Illinois Knights Templar Home - Congregate Living Units (CLU's(: 3330 Sq Ft; 11 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	120,000	1952	$ 23,000	1
2	Garage	7,850	1951	3,204	2
3	TOTALS	127,850		$ 26,204	3

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	13			1963	$ 155,247	$	40	$	$	$ 155,247	4
5	37			1975	825,217	14,771	40	20,630	5,859	618,900	5
6	6			1987	587,238	14,681	40	14,681		264,258	6
7	4			1992	64,239	1,606	40	2,606		20,878	7
8	15			1996	1,292,665	32,317	40	32,317	13,973	47,896	8
	Improvement Type**										
9	Doors			1977	10,621		15			10,621	9
10	Parking Lights			197	5,523		8			5,523	10
11	Improvements			1978	40,262	1,007	40	1,007		26,754	11
12	Generator			1979	12,921		20			12,921	12
13	Generator			1980	26,890		20			26,890	13
14	Roof			1980	32,948		20			32,948	14
15	Roof - Nurses Station			1981	22,000		20			22,000	15
16	Basement Renovation			1981	20,614		40			20,614	16
17	Air Conditioner Installation			1982	1,271		5			1,271	17
18	Carpeting - Administrators House			1982	365		5			365	18
19	Laundry Room - Plumbing & Heating			1982	9,799	245	25	392	147	9,016	19
20	Electrical Updates			1984	1,405		18			1,405	20
21	Water Heater			1984	1,430		10			1,430	21
22	Garage			1985	6,015	150	25	241	91	4,488	22
23	Furnace - Administrators House			1985	1,522		15			1,522	23
24	5 Room Renovation			1988	144,260	3,607	40	3,607		57,712	24
25	Resurface Parking Lots & Drives			1988	12,875		8			12,875	25
26	Patio			1989	9,000		15			9,000	26
27	Solarium			1989	21,547		15			21,547	27
28	Remodel Day Room			1989	3,558		15			3,558	28
29	Install Catch Basins			1989	790	20	20	40	20	640	29
30	New Sidewalk			1989	890		15			890	30
31	Sidewalk & Ramp			1990	1,090	27	15	68	41	1,090	31
32	Rewire Garage			1992	3,238	81	20	162	81	2,106	32
33	Install New Hot Water Supply			1992	3,039	76	20	152	76	1,824	33
34	Land Improvement - Cleared Site For Garage			1992	1,540		10			1,540	34
35	Garage			1992	39,976	999	15	2,665	1,666	38,142	35
36	Wall Replacement			1993	71,464	1,787	40	1,787		19,656	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Land Improvement -Removal Of Tank	1993	$ 2,500	$	10	$	$	$ 2,500	37
38	Roof Insulation	1993	15,800	790	15	1,053	263	12,636	38
39	Roof Insulation and Replace Skylights	1993	6,672	445	15	445		5,340	39
40	Wallpaper, Lights, Sashes - Adm House	1993	3,531		5			3,531	40
41	Sump Pump & Pit -Adm House	1993	815		10			815	41
42	Repaired Generator	1994	5,156	129	20	258	129	3,658	42
43	Wallpaper, Blinds, Cabinets - Adm House	1994	2,338		5			2,338	43
44	Land Improvement - Repaired Water Main	1994	1,063	72	25	43	(29)	473	44
45	Land Improvement - Sidewalks	1994	1,721	115	15	115		1,265	45
46	Air Conditioner in Dining Room	1994	4,801		5			4,801	46
47	Rewired Cable	1995	875		5			875	47
48	Tile In Front Entrance, Intermediate Rooms & House	1995	7,408	185	20	370	185	3,700	48
49	Land Improvement - Transplanted Tree	1995	275	18	20	14	(4)	140	49
50	Replace Fire System	1995	2,915	73	10	292	(117)	2,915	50
51	Installed New Shower	1996	647	16	10	65	49	568	51
52	Installed Garage Door & Asbestos Analysis	1996	1,254	31	20	63	32	567	52
53	Land Improvement - Repaired Water Main	1996	1,002	25	25	40	15	360	53
54	Remodeled Dining Room - Wallpaper	1996	550		5			550	54
55	Replaced Tile In Bath #1	1996	685	17	20	34	17	296	55
56	Installed New Fire Door	1996	4,321	108	15	288	180	2,592	56
57	Wallpaper & Blinds In Dining Room - Adm House	1996	2,136		5			2,136	57
58	Repaired Generator	1996	2,217	55	18	123	68	1,107	58
59	Replace Piping From Hot Water Heater	1996	603	15	20	30	15	270	59
60	Wallpaper & Jacks In Master Bedroom - Adm House	1997	785		5	157	157	785	60
61	Run New Water Line In Mechanical Room	1997	2,643	66	15	176	110	1,408	61
62	Installed New Door Alarms In 1995 Addition	1997	1,752	15	10	175	160	1,400	62
63	Increased Value Of Land - Demolition Of Old House	1997	51,268						63
64	Maintemance Equipment	2003	937	94	10	94		188	64
65	Wallpaper And Tile In Solarium	1997	2,586		5	518	518	2,586	65
66	Installed Wallpaper	1997	392	10	20	39	29	312	66
67	Installed New Water Line	1997	3,336	83	20	167	84	1,570	67
68	Installed Mop Sink & Ductwork For Furnace	1997	2,508	63	20	125	62	1,000	68
69	Land Improvement - Removed Trees	1997	860	57	20	43	(14)	344	69
70	TOTAL (lines 4 thru 69)		$ 3,567,811	$ 73,856		$ 85,082	$ 23,863	$ 1,518,553	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,567,811	$ 73,856		$ 85,082	$ 11,226	$ 1,518,553	1
2	Replaced Water & Sewer Lines, Sink, Faucet & Countertops	1998	3,511	51	20	176	125	1,158	2
3	Installed Mini-Blinds in Breakroom	1998	904		5			904	3
4	Land Improvement	1998	3,239		20			3,329	4
5	Land Improvement - Planted Trees	1998	699	47	20	35	(12)	222	5
6	Repaired Generator	1998	1,925	39	20	96	57	608	6
7	Installed Closet Dividers	1998	474	32	15	32		203	7
8	Repaired Roof	1998	633	63	10	63		394	8
9	Installed Oxygen Ventilation System	1998	2,980	149	20	149		906	9
10	Installed Carpet	1998	680	136	5	136		680	10
11	Land Improvement - Tested & Upgraded Fuel Tank	1998	8,050	537	25	322	(215)	1,959	11
12	Landscaping	1998	300	60	5	30	(30)	300	12
13	Concrete Driveway	1999	8,000	534	10	800	266	4,400	13
14	Roof Improvements on 1975 Addition	1999	4,776	478	10	478		2,629	14
15	Roof Improvements on 1988 Dining Room Addition	1999	10,528	1,053	10	1,053		5,792	15
16	Pavillion	1999	14,214	355	25	569	214	2,560	16
17	Electric Improvements on the 1995 Addition	1999	4,762	119	20	238	119	1,071	17
18	Kitchen Fire System	1999	1,797	37	10	180	143	810	18
19	Pavillion Lights	2000	1,235	31	10	124	93	558	19
20	Building Improvement Original Memorial Monument	2000	746	19	40	19		107	20
21	Building Improvement Original BTU Heat Pump	2000	1,988	50	40	50		200	21
22	Buildoing Improvements 1988 New Wander Guard System	2000	11,990	300	40	300		1,200	22
23	Land Improvement Sidewalk and Pad	2001	2,300	153	15	153		612	23
24	Buiilding Improvement 1975 PTAC ChaSSIS	2002	25,807	645	40	645		1,935	24
25	Garage Door	2002	675	68	10	68		204	25
26	Building Improvemnts - Handrails	2002	1,480	148	10	148		444	26
27	Ewater Heater	2002	2,378	234	10	238	4	714	27
28	Smoke Damper	2002	605	63	10	63		189	28
29	Transformer	2002	206	21	10	21		63	29
30	Building Improvements - Roofing	2003	140,166	3,504	40	3,504		7,008	30
31	Room Furnishings	2003	1,248	125	10	125		250	31
32	Buidling Improvements - Original Building	2004	17,366	434	40	434		434	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,843,473	$ 83,341		$ 95,331	$ 11,990	$ 1,560,396	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 606,927	$	$ 60,692	$ 60,692	10	$ 463,538	71
72	Current Year Purchases	67,240	3,362	3,362		10	3,362	72
73	Fully Depreciated Assets	144,110					144,110	73
74								74
75	TOTALS	$ 818,277	$ 3,362	$ 64,054	$ 60,692		$ 611,010	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility-Patient Car	Ford Aerotech,1980	1980	$ 35,800	$	$	$		$ 35,800	76
77	Facility-Maintenance	Chevy S-10,1988	1988	10,077					10,077	77
78	Facility-Patient Car	Buick Century,1993	1993	14,491					14,491	78
79										79
80	TOTALS			$ 60,368	$	$	$		$ 60,368	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,748,322	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,703	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 159,385	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 72,682	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,231,774	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Townhouse 1975	$ 104,547	$ 2,595	$ 74,760	86
87	Congregate Living Units, 1998	405,870	13,259	268,652	87
88					88
89					89
90					90
91	TOTALS	$ 510,417	$ 15,854	$ 343,412	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ N/A Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [x] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	1,732	$	34,204	$	1,732	$ 34,204	1
2	Licensed Speech and Language Development Therapist		hrs		2,247		3,440	41	2,247	3,481	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		2,727		46,765	698	2,727	47,463	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					6,772		6,772	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	6,706	$	84,409	$ 7,511	6,706	$ 91,920	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 **Report Period Beginning:** 08/01/2003 **Ending:** 07/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 07/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 80,071	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance none)	341,177		3
4	Supply Inventory (priced at cost)	26,024		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,026		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): deposits	7,783		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 472,081	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	82,951		13
14	Buildings, at Historical Cost	3,904,899		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	750,922		16
17	Accumulated Depreciation (book methods)	(2,575,186)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CLU and Townhouses	519,967		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,683,553	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,155,634	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 157,504	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,117		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payroll Expenses	35,819		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 266,440	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	6,664		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,664	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 273,104	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,882,530	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,155,634	$	48

***(See instructions.)**

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,302,433	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,302,433	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,303,509)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,303,509)	17
	B. Transfers (Itemize):		
18	**Transfer From Administrative Fund**	1,268,851	18
19	**Prior Period Adjustment**	(385,245)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 883,606	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,882,530	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,376,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	40,225	28
28a	CLU and Townhouse Income	28,469	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 68,694	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,445,069	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	796,423	31
32	Health Care	1,564,512	32
33	General Administration	1,190,278	33
	B. Capital Expense		
34	Ownership	148,427	34
	C. Ancillary Expense		
35	Special Cost Centers	18,112	35
36	Provider Participation Fee	30,826	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,748,578	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,303,509)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,303,509)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,098	2,322	$ 52,817	$ 22.75	1
2	Assistant Director of Nursing	1,947	2,179	41,762	19.17	2
3	Registered Nurses	6,800	7,176	134,951	18.81	3
4	Licensed Practical Nurses	10,546	11,230	158,276	14.09	4
5	Nurse Aides & Orderlies	30,718	33,566	334,726	9.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,978	3,242	31,786	9.80	9
10	Activity Assistants	5,304	5,764	46,592	8.08	10
11	Social Service Workers	2,850	3,170	31,619	9.97	11
12	Dietician	2,050	2,258	27,482	12.17	12
13	Food Service Supervisor					13
14	Head Cook	6,573	7,270	76,686	10.55	14
15	Cook Helpers/Assistants	15,576	16,736	135,076	8.07	15
16	Dishwashers					16
17	Maintenance Workers	6,264	6,792	88,777	13.07	17
18	Housekeepers	14,540	15,584	135,398	8.69	18
19	Laundry	3,218	3,518	42,713	12.14	19
20	Administrator	1,032	1,160	27,588	23.78	20
21	Assistant Administrator					21
22	Other Administrative	6,722	7,241	148,104	20.45	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) BEAUTICIAN	1,864	1,920	16,294	8.49	33
34	TOTAL (lines 1 - 33)	121,080	131,128	$ 1,529,784 *	$ 11.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	8,400	L9,C3	36
37	Medical Records Consultant	44	2,483	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,980	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,838	L11,C3	44
45	Social Service Consultant	32	1,838	L12,C3	45
46	Other(specify) Dietary	96	5,800	L1,A3	46
47	Barber	32	652	L40,E3	47
48	Administrator	monthly	58,673	L19,C3	48
49	TOTAL (lines 35 - 48)	236	$ 81,664		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	960	$ 49,203	L10,C3	50
51	Licensed Practical Nurses	138	5,674	L10,C3	51
52	Nurse Aides	14,663	383,961	L10,C3	52
53	TOTAL (lines 50 - 52)	15,761	$ 438,838		53

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
VP Circle of Quality	$ 58,673
TOTAL (agree to Schedule V, line 17, col. 3)	$ 58,673
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WDM COMPUTER SERVICES	PAYROLL	$ 3,023
DUANE MORRIS & HECKSCHER	LEGAL	123,435
LAWRENCE TRAVIS & CO PC	AUDITING	11,000
LAWRENCE TRAVIS & CO PC	CONSULTING	4,152
ACCU-MED	COMPUTER CONSULTING	6,540
AMERICAN EXPRESS	CONSULTING	6,867
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 155,017

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,168
Unemployment Compensation Insurance	18,800
FICA Taxes	120,442
Employee Health Insurance	324,561
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	0
Other Employee Benefits	23,458
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,429

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,126
Health Care Worker Background Check	
(Indicate # of checks performed)	
Mailers	16,422
Dues and subscriptions	6,185
Licenses	98
Utilization review	550
Support fees	6,750
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,131

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Illinois Knights Templar Home # 0010058 Report Period Beginning: 08/01/2003 Ending: 07/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Illinois Knights Templar Home **#** 0010058 **Report Period Beginning:** 08/01/2003 **Ending:** 07/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **No** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Lawrence Travis & Co PC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Illinois Knights Templar Home
Provider ID Number - 0010058
Year- end July 31,2004

Attendees	Title	Dates	Location	Sponsor	Cost
Administration	Compliance	3/9/2004	Springfield	Life Services	2745
Administration	Compliance	10/16/2003	Springfield	Health Technologies	1140
Accounting	Training	10/30/2003	Springfield	Cross Country Univers	169
Nursing	Compliance	2/13/2004	Champaign	Health Services	378
Adminstration	Compliance	2/26/2004	Mattoon	Lake Land College	340
Nursing	Training	10/15/2003	Paxton	Enloe	300
					5072
			Total		